NORTH CENTRAL FAMILY DENTAL

PATIENT INFORMAITON

Date: _____ Email: _____

Last Name: _____ First Name: _____ Mi: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Date of Birth:_____ Social Security #:_____ Sex: Male or Female

Marital Status: Single Married Divorced Widowed Separated

Employer or School: _____ Occupation: _____

Employer Address: _____City:_____ State: _____ Zip: _____

Whom may we thank for referring you to our office_____

RESPONSIBLE PARTY

Spouse or Guardian Last Name: _____ First Name_____

Mailing Address: _____City:_____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Employer Name: _____ Address: _____

City:_____ State: _____ Zip: _____

Is the financially responsible party a patient in our office: Yes or No

Method of payment for the dental care: Insurance _____

Credit Card _____

I wish to discuss payment option _____

Dental Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec or ID #: _____ Insured Date of Birth: _____

Name of Employer: _____ Group #: _____

Name of Insurance: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec or ID #: _____ Insured Date of Birth: _____

Name of Employer:_____ Group#:_____

Name of Insurance: _____ Address: _____

City: _____ State: _____ Zip: _____

TURN OVER

DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam _____

DO YOU NEED ANTIBIOTICS PRIOR TO RECEIVING DENTAL CARE? IF YES, PLEASE EXPLAIN:

_____

HAVE YOU HAD AN ORTHOPEDIC TOTAL JOINT (HIP, KNEE, ELBOW, FINGER) REPLACEMENT?

_____

1) How many times a day do you brush your teeth? _____

2) Do your gums bleed while brushing of flossing? ---------- Yes No

3) Are your teeth sensitive to hot or cold liquids/foods? ---------- Yes No

4) Are your teeth sensitive to sweet or sour liquids/foods? ---------- Yes No

5) Do you have any sores or lumps in or near your mouth? ---------- Yes No

6) Have you had any head, neck or jaw injuries? ---------- Yes No

7) Have you ever experienced any of the following problems in your jaw?

   Clicking---------- Yes No

   Pain (joint, ear, side of face) ---------- Yes No

   Difficulty in opening or closing---------- Yes No

   Difficulty in chewing ---------- Yes No

8) Do you have frequent headaches? ---------- Yes No

9) Do you clench or grind your teeth? ---------- Yes No

10) Do you bite your lips or cheeks frequently? ---------- Yes No

11) Have you ever had any difficult extractions in the past? ---------- Yes No

12) Have you every had any prolonged bleeding following extractions? --- Yes No

13) Have you had any orthodontic treatment? ---------- Yes No

14) Do you wear dentures or partials? ---------- Yes No

   If yes How old are they?_____

15) Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ----------Yes No

16) Do you like your smile? ---------- Yes No